Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Compliance Toxicology LLC

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-14-3615-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
August 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…It is the belief of this CLIA ancillary provider that preauthorization is not required for this service. It is not usual or customary for this ancillary provider to have access to or provide documentation to support medical necessity…"

Amount in Dispute: $1,945.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office performed an in-depth review of the disputed charges and determined pursuant to Rule 134.600(p) which stated "Non-emergency health care requiring preauthorization includes (12) treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2014	Urine Drug Screen	$1,945.00	$1,116.61

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.210 sets out documentation requirements.
3. 28 Texas Administrative Code §137.100 sets out treatment gudielines.
4. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for clinical laboratory services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment denied/reduce for absence of precertification/preauthorization.
   - Note – Documentation attached does not support the necessity for monthly urine drug screening.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did the carrier follow the appropriate administrative process to address the assertions made in its response to medical fee dispute?
2. What is the applicable rule pertaining to reimbursement?
3. Is reimbursement due?

Findings

1. The carrier, in its response to this medical fee dispute, makes assertions that question the appropriateness of the disputed care/services. For example, the insurance carrier states "Review of the "Pain" chapter of the ODG does recommend Urine drug screening that meets the critiera. …the clinical documentation does not discuss the patient already receiving a controlled substance or conronic opiod management is being considered. The ODG states that Urine drug testing is not generally recommeneded in acutre treatment settings. Furthermore, there is no discussion of the patient being at "high risk" for addiction as there is no addiction screening included in this evaluation. The critieria also states that Quantitiative uring drug testing is not recommended for verifying compliance with out evidence of medical necessity.." Although the carrier's assertions are made based on language taken from the ODG, the issues raised in the carrier's response to medical fee dispute resolution indicate that the carrier may be asserting denial of payment based on an exsiting, unresolved issue of medical necessity. No documentation was found that demonstrates the existence of an unresolved issue of medical necessity, prior to the date the request for medical fee dispute resolution was filed.

   Furthermore, the division notes that 28 TAC §137.100 (e) sets out the appropriate administrative process for the carrier to retrospectively review reasonableness and medical necessity of care already provided. Section (e) states:

   > "An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017."

   Retrospective review is defined in 28 TAC §19.2003 (28) as "The process of reviewing health care which has been provided to the injured employee under the Texas Workers' Compensation Act to determine if the health care was medically reasonable and necessary." 28 TAC §19.2015(b) titled *Retrospective Review of Medical Necessity* states:

   > (b) When retrospective review results in an adverse determination or denial of payment, the utilization review agent shall notify the health care providers of the opportunity to appeal the determination through the appeal process as outlined in Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers)."

   The division finds that the carrier failed to follow the appropriate administrative process to address the assertions made in its response to this medical fee dispute. Therefore, the denial based on ODG guidelines being exceeded thus requiring pre-authorization will not be considered in this review.

2. 28 TAC §134.203(e) states: "The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows: 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service." CMS payment policy files identify those clinical laboratory codes which contain a professional component, and those which are considered technical only. The codes in dispute are not identified by CMS as having a possible professional component, for that reason, the MAR is determined solely pursuant to 28 TAC §134.203(e)(1). The maximum allowable reimbursement(MAR) for the services in dispute is 125% of the fee listed for the codes in the 2014 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at http://www.cms.gov. The services in dispute will be calculated as follows;

Date of Service	Submitted Code	Submitted Charge	Units	Maximum allowable reimbursement (Clinical lab fee schedule x 125%)
February 18, 2014	G0431	300.00	5	75.82 x 125% = 94.78 x 5 = 473.88
February 18, 2014	82570	35.00	1	7.06 x 125% = 8.83
February 18, 2014	83986	35.00	1	4.88 x 125% = 6.10
February 18, 2014	82542	60.00	1	24.63 x 125% = 30.79
February 18, 2014	80154	80.00	1	25.23 x 125% = 31.58
February 18, 2014	80299	140.00	2	18.68 x 125% = 23.35 x 2 = 46.70
February 18, 2014	82145	60.00	1	21.20 x 125% = 26.50
February 18, 2014	82205	70.00	1	15.62 x 125% = 19.53
February 18, 2014	82520	130.00	2	20.68 x 125% = 25.85 x 2 = 51.70
February 18, 2014	83840	140.00	2	22.28 x 125% = 27.85 x 2 = 55.70
February 18, 2014	83925	320.00	4	26.54 x 125% = 33.18 x 4 = 132.72
February 18, 2014	83805	80.00	1	24.04 x 125% = 30.05
February 18, 2014	82646	85.00	1	28.17 x 125% = 35.21
February 18, 2014	82649	85.00	1	35.07 x 125% = 43.84
February 18, 2014	82205	70.00	1	15.62 x 125% = 19.53
February 18, 2014	83789	65.00	1	24.63 x 125% = 30.79
February 18, 2014	80152	60.00	1	24.42 x 125% = 30.53
February 18, 2014	80182	65.00	1	18.49 x 125% = 23.11
February 18, 2014	80184	65.00	1	15.62 x 125% = 19.52
Total		$1,945.00		$1,116.61

3. The total recommended payment for the services in dispute is $1,116.61. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $1,116.61. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $1,116.61.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,116.61 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		February 26, 2015
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.